DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES 45th 12/09/17 70th 1/03/18

PRINTED: 11/06/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING _____ B. WING _____	10/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

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F 000	INITIAL COMMENTS An annual Recertification survey and investigation of complaint #42680 was conducted on 10/23/17 through 10/25/17 at Alexian Village of Tennessee. No deficiencies were cited related to the complaint under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	*Alexian Village Health and Rehabilitation Center offers this Plan of Correction as its allegation of compliance with the participation requirements for long term care facilities and as evidence of its ongoing efforts to provide quality care to residents.* ***Disclaimer Statement*** *Alexian Village Health and Rehabilitation Center does not admit that any deficiencies existed, before, during or after the survey. Alexian Village Health and Rehabilitation Center reserves all rights to contest the survey findings through the IDR, formal appeal proceeding or any administrative or legal proceedings. This POC is not meant to establish any standard of care or contractual obligation and Alexian Village Health and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this POC should be deemed applicable to peer review, quality assurance or self-critical examination privileges which Alexian Village Health and Rehabilitation Center does not waive.*	
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the walls in good repair in 4 of 19 rooms on 1 of 4 floors. The findings included: Observation of room 505 on 10/23/17 at 2:15 PM revealed there were several areas with white mudding (compound to smooth drywall) on the painted green wall at the head of the bed. Observation and interview with the Maintenance Director on 10/24/17 at 3:50 PM of the wall in room 505 revealed there were 9 areas of mudding on the wall, with the largest area measuring approximately 36 inches in length. Continued interview confirmed the wall was in need of repair/painting. Interview with the facility's painter with the Maintenance Director present on 10/24/17 at 4:00 PM, in the hallway revealed the wall had been mudded 6 months ago and confirmed the green	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11-15-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 wall had not been repainted after the mudding. Observation and interview with the Maintenance Director on 10/25/17 at 9:30 AM of the walls in rooms 503, 513, and 519, confirmed the walls had areas of sheetrock showing and were in need of repair.	F 253	*QAPI Committee Members –* *Executive Director* *Administrator* *Sponsor Liaison* *Medical Director* *Pharmacy Consultant* *Director of Nursing* *Assistant Director of Nursing* *Director of Quality* *Case Management* *Medical Records* *Dietician* *MDS Director* *MDS Nurse* *Dining Services* *Activities* *Environmental Services* *Director of Plant Operations* *Facility Services* ***F 253 483.10(l)(2) HOUSEKEEPING & MAINTENANCE*** 1) Walls were repaired and painted in identified room on 10/27/17. 2) 5th floor rooms audited and	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 315		

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F 315	Continued From page 2 (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to assess 1 resident (#123) for a toileting program of 2 residents reviewed for urinary incontinence of 28 residents reviewed. The findings included: Review of the facility's policy Restorative Nursing - Toileting Program, revised 12/2016, revealed "...Residents who are incontinent are assessed by Nursing and/or Therapy for a Toileting program to promote Independence and quality of life by maintaining or improving a resident's continence...A. Appropriate residents for the program may include the following: 1. Residents who are incontinent...4. Residents who require limited to extensive assistance in toilet use; 5. Residents who have difficulty notifying staff when they have the urge to void...B. Resident continence is assessed on admission, with significant changes and quarterly: 1. Check resident approximately hourly and document in the resident's medical record as continent, incontinent or soiled and level of assistance. 2. During the assessment period, associates honor the resident's request to toilet, but do not offer to take them as this interferes with the results of the incontinence pattern. 3. After 3 days analyze data...Determine patterns in frequency, volume,	F 315	maintenance is fixing any wall damage identified. 3) Director of Maintenance or designee will educate maintenance staff on expectation of wall appearance and process of inspection. 4) Maintenance will inspect each resident room in health care weekly for damage to walls, and repair as needed. Monitor rooms monthly for timely completion of wall repairs for 6 months. Audits will be reported to QAPI meeting monthly for a total of 6 months. ***F 315 483.25€(1)-(3) NO CATHETER, PREVENT, UTI, RESTORE BALADDER*** 1) Identified resident had a voiding diary restarted and toileting plan in place. 2) MDS nurses audited all current residents MDS for decline in bowel/bladder function and initiated appropriate voiding diaries as identified. 3) Quality Director or designee will educate nursing staff on process of initiating voiding diaries on or	11/17/2017

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F 315	Continued From page 3 duration, and time of day..." Medical record review revealed Resident #123 was admitted to the facility on 5/12/17 with diagnoses including Dementia, Coronary Angioplasty Status, Presence of Cardiac Pacemaker, Congestive Heart Failure, Hypertension, Muscle Weakness, and Dysphasia. Medical record review of the admission Minimum Data Set (MDS) dated 5/19/17 revealed the resident scored a 4 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognitive skills, required extensive assistance of 1 person with transfers, walking in room, and toilet use, and was frequently incontinent of bladder. Medical record review of the significant change of status MDS dated 6/15/17 revealed the resident had a BIMS of 6, indicating the resident had severely impaired cognitive skills, required extensive assistance of 1 person with transfers, walking in room, and toilet use, and was always incontinent of bladder. Medical record review revealed no documentation the resident's continence pattern had been documented approximately hourly for 3 days then assessed to determine a pattern of incontinence or the type of incontinence after the resident's decline in urinary incontinence. Interview with Registered Nurse (RN #1) on 10/24/17 at 3:30 PM, in the conference room, confirmed the continence pattern was not completed after Resident #123's decline in continence identified on the 6/15/17 MDS to determine if the resident would benefit from a	F 315	before 11/17/17. MDS department will monitor 5 MDS's per month for 6 months for appropriate initiation of voiding diaries if a decline in bowel/bladder was identified. 4) Audits will be reported to QAPI meeting monthly for 6 months.	11/17/2017

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F 315	Continued From page 4 toileting program.	F 315		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441	***F441 483.80(a)(1)(2)(4)(e)(f)*** ***INFECTION CONTROL PREVENT SPREAD, LINENS*** 1) Regulation, policy and procedure for disinfecting blood glucose monitor were reviewed to maintain compliance with state and federal requirements. 2) No other residents or incidents were identified. 3) Quality Director or designee will re-educate nurses on following policy and procedure for disinfecting blood glucose monitor on or before 11/17/17. 4) Quality Director or designee will observe 5 staff members for appropriate completion of procedure weekly x4 and then monthly for a total of 6 months. Observation results will be reported to QAPI meeting monthly for a total of 6 month.	11/17/2017

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F 441	Continued From page 5 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, manufacturer's recommendation, observation, and interview, the facility failed to ensure staff maintained infection control for the glucose meter and to disinfect the glucose meters with appropriate disinfectant for 3 of 6 nurses observed. The findings included:	F 441		

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F 441	Continued From page 6 Review of the facility's policy, Obtaining a Fingerstick Glucose Level, revised date 12/2016, revealed "...Steps in the Procedure..Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice..." Review of the manufacturer's recommendation user guide revealed "...page 42/43. Cleaning and disinfecting meter and lancing device is very important in the prevention of infectious disease...The following products are validated for disinfecting the [product name] [named cleaning wipe]..." Observation on 10/24/17, at 7:50 Am, revealed Licensed Practical Nurse (LPN) #1, was preparing to perform a blood glucose test. Continued observation revealed the LPN#1 removed the glucose meter from medication cart and placed the meter in her uniform pocket. Observation revealed the LPN entered the resident's room, removed the glucose meter from uniform pocket, placed the glucose meter on the resident's overbed table. Continued observation revealed after the LPN obtained the resident's blood glucose, she placed the glucose meter in her uniform pocket. Observation revealed the LPN returned the glucose meter to the medication cart and placed the meter on top. Further observation revealed the LPN disinfected the glucose meter with alcohol pads. Observation on 10/25/17, at 7:50 AM, revealed LPN#2 was preparing to check a blood glucose for a resident. Continued observation revealed LPN#2 took the glucose meter in the resident's room, obtained blood glucose, returned the glucose meter to the medication cart.	F 441		

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F 441	Continued From page 7 Observation revealed LPN #2 disinfected the glucose meter with alcohol pads. Observation on 10/25/17, at 8:00 AM, revealed LPN #3 was preparing to check a blood glucose for a resident. Observation revealed LPN #3 took the glucose meter in the resident's room, placed meter on the resident's bed, and obtained the blood glucose. Continued observation revealed LPN #3 returned the glucose meter to medication cart and placed in the drawer without disinfecting. Interview with LPN #3 at the time of observation confirmed LPN #3 had not disinfected the glucose meter before placing in the medication cart. Interview with the Director of Nursing (DON) on 10/24/17, at 1:30 PM, in the DON's office, confirmed the glucose meter was to be disinfected using the manufacturer's recommendation, [named cleansing wipe] and staff were not to carry the glucose meter in their uniform pocket. Interview with the DON on 10/25/17, at 8:25 AM, in the conference room, confirmed the facility had failed to follow policy and manufacturers' recommendation for disinfecting the glucose meter.	F 441		